## CONSENT TO RELEASE INFORMATION FROM A BIRTH RELATIVE OR ADOPTIVE FAMILY MEMBER

If any of the requested information is unknown, please print "Unknown" in the appropriate space.

I,	,
(Current Name)	(Social Security Number)
am the of of	
who was born on in in	(Place of Birth)
If a birth parent, my name at the time of the adoptee's birth	
if a birth parent, my hame at the time of the adoptee's birth	was
This child's adoption was initiated or finalized in the State of	of Maryland, and the petition was filed by (check one):
A Local Department of Social Services in	(County/City)
A Private Child Placement Agency (name	e) or
An Independent Agent (attorney's name)	
Pursuant to the Code of Maryland Regulations (COMAR) 0 give permission, to the Department of Human Services/Soci private child placement agency to do the following concernito occur, and "No" by the actions you do not want to occ	ial Services Administration (DHS/SSA), and/or the ing the adoptee ( <b>print "Yes" by the actions you want</b>
Release my updated medical information	Facilitate written contact
Release my name and address	Facilitate telephone contact
Release my telephone number	Facilitate a reunion
Release my email address	
I will notify DHS/SSA of any change of name and/or address these changes, I am providing the name, address and telephone I can be contacted:	
(Name, Address, Telephone N	Number)
I understand that I may withdraw my consent to release iden	ntifying information in writing at any time.
SIGNATURE	DATE
ADDRESS	
HOME PHONE NUMBER WORK PHONE	NUMBER
Notary Public:	Date:
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